DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01-10

2. STATE: **ILLINOIS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT
a. FFY 01 $ 0
b. FFY 02 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B Pages 26-32

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B Pages 26-32

10. SUBJECT OF AMENDMENT:

FQHC/RHC

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL: Jackie Garner

13. TYPED NAME: **Jackie Garner**

14. TITLE: **DIRECTOR**

15. DATE SUBMITTED

16. RETURN TO:

ILLINOIS DEPARTMENT OF PUBLIC AID
201 SOUTH GRAND AVENUE, EAST
SPRINGFIELD, IL. 62763-0001
ATTENTION: John Rupcich

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 3/30/01

18. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/01

19. PLAN APPROVED - ONE COPY ATTACHED

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

FORM HCFA-179 (07-92) *Instructions on Back*

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2. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

a. Definitions.

"Federally qualified health center" (FQHC) means a health care provider that receives a grant under Section 330 of the *Public Health Service Act* or be determined to meet the requirements for receiving such a grant by Health Resources and Services Administration.

"Rural health clinic" (RHC) means a health care provider that has been designated by the U.S. Public Health Service, or by the Governor and approved by the U.S. Public Health Service, in accordance with the *Rural Health Clinics Act* to be a RHC.

"Center," for the purposes of this section, means both a FQHC and a RHC.

b. Reimbursement.

Centers will be reimbursed under a prospective payment system (PPS), in accordance with the provisions of section 1902(aa) of the *Social Security Act*, for 100 percent of the reasonable and efficient costs incurred by the Center. A baseline payment rate will be determined individually for each enrolled Center. Once determined, the baseline payment rates will be adjusted annually using the Medicare Economic Index (MEI).

Payment for services provided on or after January 1, 2001, shall be made using a specific rate for each Center as specified herein.

i. Baseline payment rates.

A. For each Center, the Department will calculate a baseline medical encounter rate and, for each Center that offers dental services, a baseline dental encounter rate, using the methodology specified herein. The cost basis for the baseline rates shall be drawn from cost reports for Center fiscal years ending in 1999 and 2000 or, in the instance of a Center that did not operate during the entirety of those periods, cost reports that cover the portions of those periods during which the Center was in operation.

B. The baseline payment rate shall be based upon allowable costs, reported by the Center, that are determined by the Department to be reasonable and efficient. The method for determining allowable direct cost factors is similar to that used for Medicare. There are two significant differences: (1) the Department's methodology considers costs associated with services not covered under Medicare (*e.g.*, pharmacy, patient transportation, medical case management, health education, and nutritional counseling); and, (2) reasonable constraints on allowable overhead cost, as described in v.D below, and total cost per encounter.

C. The baseline payment rate for a Center shall be the average (arithmetic mean) of the annual reasonable costs per encounter, calculated separately for each the fiscal years for which cost report data must be submitted, using the methodology specified in D for the medical encounter rate and E for the dental encounter rate.

D. Annual reasonable cost per medical encounter.

1. The annual reasonable cost per medical encounter shall be the lesser of:

— The annual cost per encounter, as calculated in D.4; or

— The reasonable cost of providing a medical encounter, which shall be 105 percent of the statewide median of the calculated annual costs per encounter for FQHCs or RHCs, as the case may be.

2. Core services component.

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The core services component is the sum of the following two components:

— The allowable direct cost per encounter, which is the quotient of the allowable direct cost, as defined in i.B, for core services divided by the greater of (1) number of encounters reported by direct staff, or (2) the number of encounters resulting from the application of the minimum efficiency standard found in v.A, and

— The allowable overhead cost per encounter, which is the product of the allowable direct cost per encounter multiplied by the Center's allowable overhead rate factor.

3. Supplemental services component.

The supplemental services component is the sum of the following two components:

— The allowable supplemental cost per encounter, which is the quotient of the cost of pharmacy, patient transportation, medical case management, health education, nutritional counseling, and other non-core services, excepting only dental services, provided by the Center, divided by the greater of (1) the number of encounters reported by direct staff or (2) the number of encounters resulting from application of the minimum productivity standard found in v.A, and

— The allowable overhead cost per encounter, which is the product of the allowable supplemental cost per encounter multiplied by the Center's allowable overhead rate factor.

4. Annual cost per encounter.

The annual medical cost per encounter is the sum of the core services component, as determined in C.2, and the supplemental services component, as determined in C.3.

E. Annual reasonable cost per dental encounter.

1. The annual reasonable cost per dental encounter shall be the lesser of:

— The annual cost per encounter, as calculated in E.2; or

— The reasonable cost of providing a dental encounter, which shall be 105 percent of the statewide median of the calculated annual costs per encounter for FQHCs or RHCs, as the case may be.

2. Annual cost per encounter.

The annual cost per encounter is the sum of the following two components:

— The allowable direct cost per encounter, which is the quotient of the allowable direct dental cost, as defined in i.B, divided by the greater of (1) the number of encounters reported by direct dental staff, or (2) the number of encounters resulting from the application of the minimum efficiency standard found in v.B, and

— The allowable overhead cost per encounter, which is the product of the allowable direct cost per encounter multiplied by the Center's allowable overhead rate factor.

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F. For any individual eligible under the medical assistance programs administered by the Department, Center may bill only one medical encounter and one dental encounter per day.

G. Claims submitted to the Department must comply with the requirements in the applicable provider handbook and related provider notices and must identify all services provided during the encounter.

ii. Cost basis.

Each Center must annually complete a cost report, in a format specified by the Department, for the Center's fiscal year. Each FQHC must also annually submit a copy of financial statements audited by an independent Certified Public Accountant. The cost report and audited financial statements must be filed with the Department within 180 days of the close of the Center's fiscal year, except for cost reports and audited financial statements for Center fiscal years 1999 and 2000 which, in the case of FQHCs must be filed with the Department no later than November 30, 2001, and in the case of RHCs, must be filed no later than March 30, 2002. Except for the first year during which the Center begins operations, the cost report must cover a full fiscal year ending on June 30 or other fiscal year which has been approved by the Department. Payments will be withheld from any Center which has not submitted the cost report by the applicable filing deadline, until such time as the reports or audited statements are received and approved by the Department.

iii. Establishment of initial year payment amount for a new Center.

For any Center that begins operation on or after January 1, 2001, the payment rate per encounter shall be median of the payment rates per encounter of neighboring FQHCs or RHCs, as the case may be, with similar caseloads. If the Department determines that there are no such comparable Centers, then the rate per encounter shall be the median of the payment rates per encounter for all FQHCs or RHCs, as the case may be, statewide.

iv. Rate adjustments.

A. Initial rate determinations

1. On or about January 1, 2002, the Department shall determine the medical and dental encounter rates for each participating FQHC. These rates shall be paid for services provided on or after January 1, 2001. Claims submitted prior to the entry of these rates into the Department's claims processing system shall be reconciled for each affected FQHC.

1.

2. On or before January 1, 2003, the Department shall determine the medical and dental encounter rates for each participating RHC. These rates shall be paid for services provided on or after January 1, 2001. Claims submitted prior to the entry of these rates into the Department's claims processing system shall be reconciled for each affected RHC.

B. Annual adjustment

Beginning January 1, 2002, and annually thereafter, the Department will adjust baseline rates by the most recently available MEI. The adjusted rates shall be paid for services provided on or after the date of adjustment.

C. Scope of service adjustment.

If a Center significantly changes its scope of services, the Center may request that a new baseline encounter rate be determined. Adjustments to encounter

rates will be made only if the change in the scope of services results in a difference of at least five percent from the Center's current rate. The Department may initiate a rate adjustment, based on audited financial statements and cost reports, if the scope of services has been modified in a way that would result in a change of at least five percent from the Center's current rate.

v. Reasonable cost considerations.

The following minimum efficiency standards will be applied to determine reasonable cost:

A. Medical direct care productivity.

The Center must average 4,200 encounters annually per full-time equivalent (FTE) for physicians and 2,100 encounters per FTE for mid-level health care staff (*i.e.*, physician assistants, nurse practitioners, specialized nurse practitioners, and nurse midwives).

B. Dental direct care productivity.

The FQHC must average 1.5 encounters per hour per FTE for dentists.

C. Guideline for non-physician health care staff.

The maximum ratio of staff is four full-time equivalent non-physician health care staff for each FTE staff subject to the direct care productivity standards in A and B above.

D. Allowable overhead.

The maximum Medicaid allowable overhead cost is 35 percent of allowable direct cost.

vi. Adjustments for medical services paid for by a health maintenance organization.

The Department shall make payment adjustments to a Center if it provides care through a contractual arrangement with a Medicaid Managed Care Organization (MCO) and is reimbursed an amount, reported to the Department, that is less than the minimum payment required in 42 *U.S.C.* 1396a(aa). All such services must be defined in a contract with an MCO. Such contracts must be made available to the Department. For each Center so eligible, a payment adjustment shall take into consideration the total payments made by the MCO to the Center (including all payments made on a service-by-service, encounter, or capitation basis) and any transitional payments made by the Department as defined in Attachment 4.19-B, page 1.E. In the event that Center cost data related to MCO services are unavailable to the Department, an estimate of such costs may be used that takes into

consideration other relevant data. Adjustments will be made, no less often than quarterly, only for Medicaid eligible services as defined in this State Plan. All such services must be defined in a contract with an MCO. Such contracts must be made available to the Department.

vii. Audits.

All cost reports will be audited by the Department. The center will be advised of any adjustment resulting from these audits.

vii. Appeals.

Appeals of audit adjustments or rate determinations must be submitted in writing to the Department. All appeals submitted within 30 days of rate notification shall, if upheld, be made effective as of the beginning of the rate year. The effective date of all other upheld appeals shall be the first day of the month following the date the complete appeal was submitted. The Department shall rule on all appeals within 120 days of the date of the appeal except that, if the Department requires additional information from the Center, the period shall be extended until such time as the information is provided. Appeals for any rate year must be filed before the close of the rate year.

viii. Alternate payment methodology for government-operated Centers.

A Center operated by a State or local government agency may elect to be reimbursed under the alternate payment methodology described in this subsection viii.

A. The State or local government agency shall enter into an interagency or intergovernmental agreement, as appropriate, with the Department that specifies the responsibilities of the two parties with respect to services provided by the Center and the funding thereof.

B. The Center operated by a State or local government agency shall be reimbursed by the Department on a per encounter basis according to the provisions of subsections i through vii of this section.

C. The State or local government agency shall certify the expenditure of public funds in excess of reimbursement received from the Department, under paragraph B, and any reimbursement from other payers (*e.g.*, an insurance company, a managed care organization) for services provided to individuals eligible for medical assistance programs administered by the Department, provided the funds were not derived from a federal funding source or were not otherwise used as a State or local match for federal funds. The certification shall be in a form and format specified by the

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Department. The certification shall be filed within 30 days after the submission of the annual cost report. The certification shall compare expenditures within that cost reporting period to payments received/receivable for that same period.

D. The certified expenditures shall be used by the Department to claim federal financial participation. Federal funds resulting from the claiming of the certified expenditures shall be distributed, according to the provisions of the agreement referenced in paragraph A, to the State or the government agency that operates the Center that provided the services.

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~~3. RURAL HEALTH CLINICS: Depending on type of clinic in which services are provided: Hospitals and encounter rate clinics: same as described in 1 and 2, respectively. For others and for non-Medicare covered services, fee-for-service subject to Department's established pricing screens.~~

7/01 4. PRESCRIBED DRUGS:

Effective ~~December 15, 2000~~, July 1, 2001, pharmacies will be reimbursed for prescribed drugs on the following basis: the lower of either their usual and customary charge to the general public, or the lower of :

7/01	a.	Single and multiple source legend products for which the average wholesale price is actual market average wholesale price	–	actual market wholesale cost plus dispensing fee
7/01	b.	Other single source legend products	–	standard package size AWP of NDC on claim, less ~~10~~11%, plus a dispensing fee ~~or the wholesale acquisition cost plus 8% plus a dispensing fee~~
7/01	c.	Other multiple source legend products not approved for generic interchange by the Illinois Department of Public Health	–	standard package size AWP of NDC on claim, less ~~12~~ 20% plus a dispensing fee ~~or wholesale acquisition cost plus 12% plus a dispensing fee~~ or HCFA FUL plus a dispensing fee
7/01	d.	Other multiple source legend products approved for generic interchange by the Illinois Department of Public Health, ~~but not on the HCFA FUL list~~	–	~~standard package size AWP of NDC on claim, less 12%, plus a dispensing fee or a State upper limit plus a dispensing fee or wholesale acquisition cost plus 12% plus a dispensing fee~~
			–	standard package size AWP of NDC claim, less ~~12~~ 20% plus a dispensing fee, ~~or~~ State Upper Limit plus a dispensing fee or HCFA FUL unit price plus a dispensing fee ~~or wholesale acquisition cost plus 12% plus a dispensing fee~~
	~~d.~~	~~Multiple source legend products approved for generic interchange by the Illinois Department of Public Health, and on the HCFA FUL list~~		

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